

WEBINAR WEDNESDAYS



Wednesday, October 13, 2020

SEXUAL ASSAULT INVESTIGATIONS

Presented by:

Samantha Mendez

Forensic Nurse Educator
HonorHealth Forensic Nurse Examiners

&

Angela Rose

Director of training
New Life Center

Distributed by:

ARIZONA PROSECUTING ATTORNEYS' ADVISORY COUNCIL
3838 N. Central Ave., Suite 850
Phoenix, Arizona 85012

ELIZABETH BURTON ORTIZ
EXECUTIVE DIRECTOR

INSTRUCTIONS TO THE INVESTIGATING OFFICER:

1. Fill in information below not completed by Physician or SANE. **Also complete a Laboratory Analysis Request Form.**
2. If clothing not collected and packaged by Medical-Forensic examiner: Collect and place the patient's AIR-DRIED garments that may contain evidence (especially semen), in separate clean paper bags, seal and initial for submission to the Crime Laboratory.
3. To obtain the best results from an evaluation of this evidence, a brief summary of the alleged incident **MUST** be submitted with the evidence and the "Laboratory Analysis Request Form" form.

EXAMINING PHYSICIAN OR SANE, COMPLETE THE FOLLOWING:

AGENCY: Phoenix	CITY: Phoenix	COUNTY: Maricopa	AGENCY REPORT NUMBER: 123
VICTIM/PATIENT NAME: LAST: Testpatient, Donotdelete FIRST:		MIDDLE (If NONE, Check Box) A <input type="checkbox"/> None	DATE OF BIRTH: (mm/dd/yy) 01/18/90
DATE OF ASSAULT: (mm/dd/yy) " Today " - 6/11/2020		DATE OF EXAM: (mm/dd/yy) 06/11/20	
TIME OF ASSAULT: (24 hour clock) " Around 2 am "		TIME OF EXAM: (24 hour clock) 1212	
FACILITY WHERE EXAM PERFORMED: Facility: Family Advocacy Center City: Phoenix County: Maricopa			
INVESTIGATING OFFICER: LAST NAME, Braff, Z	FIRST NAME,	MI	ID #: 123

EVIDENCE COLLECTION AND SEALING: TO BE COMPLETED BY EXAMINING PHYSICIAN OR SANE

CHECK ALL ITEMS THAT ARE COLLECTED:		LIST CLOTHING COLLECTED:
<input type="checkbox"/> Step 1 - Debris Collection (describe)	<input checked="" type="checkbox"/> Step 6 - Anal Swabs	short
<input type="checkbox"/> Step 2 - Oral Swabs	<input checked="" type="checkbox"/> Step 7 - Pubic Hair Combing	shirt
<input checked="" type="checkbox"/> Step 3 - Buccal Swabs	<input checked="" type="checkbox"/> Step 8 - External Genital Swabs	
<input checked="" type="checkbox"/> Step 4 - Body Surface Swabs (site): circumoral, neck, breasts, pelvis	<input checked="" type="checkbox"/> Step 9 - Vaginal Swabs	
<input type="checkbox"/> Step 5 - Body Surface Swabs (site):	<input checked="" type="checkbox"/> Step 10 - Vaginal Aspirate	
	<input type="checkbox"/> Step 11 - Blood: <input type="checkbox"/> purple <input type="checkbox"/> gray	
	<input checked="" type="checkbox"/> Step 12 - Underpants or Diaper	<input type="checkbox"/> Changing Sheet
	<input checked="" type="checkbox"/> Step 13 - Bra or Other:	<input checked="" type="checkbox"/> Urine Collected (if indicated)

1. NOTE: Expiration date applies to the Blood Collection Tube ONLY. If expired, REPLACE with the same type of tube from hospital stock.
2. Refer to the enclosed envelopes for "STEP-BY-STEP" INSTRUCTIONS. *Collect if indicated.*
ALL SWABS MUST BE DRIED IMMEDIATELY AFTER COLLECTION. Preferred method for drying is using a swab drying box or air dry to complete process.
3. Envelope Sealing Instructions: **DO NOT MOISTEN FLAPS TO SEAL**
 - a. Place samples in appropriate envelope. Seal each individual envelope with clear packing tape OR HOSPITAL LABEL (not scotch tape). **NOTE SPECIFIC SEALING INSTRUCTIONS ON DEBRIS, PUBIC HAIR, AND BLOOD ENVELOPES.**
 - b. Person sealing the envelopes should place their initials on the tape or label seal.
4. Put **BLOOD SAMPLE** in a *separate sealed* envelope and **REFRIGERATE**. (Do not seal inside kit.) If **URINE** collected, put in a *separate sealed* envelope and **REFRIGERATE** or **FREEZE** (as required by agency). (Do not seal inside kit.)
5. Place all envelopes (except blood and urine) including the original envelope into double pouched bag, along with the completed original copy of report (include ALL pages whether used or not). Seal with clear packing tape. Place initials, date and time sealed across each tape seal. Place the completed chain of custody form in the outside pouch.
6. **REFRIGERATE** or **FREEZE** clothing and kit.

CHAIN OF CUSTODY:

FROM NAME:	TO NAME:	DATE:	TIME:
Samantha Mendez RN	FAC Refrigerator	06/11/20	1438

- ☒ Kit seal was intact prior to use: SM (Initials)
- ☒ Swabs and evidence dried on (date) 06/11/20 at (time) 1421 by Samantha Mendez RN
- ☒ Kit sealed on (date) 06/11/20 at (time) 1437 by Samantha Mendez RN

Distribution: White - Crime Lab

Yellow - Law Enforcement

Pink - Hospital/facility

Chain of Custody

STATE OF ARIZONA

SEXUAL ASSAULT EXAMINATION REPORT

Agency Name: **Phoenix**
 Agency Report #: **123**
 Medical Record #: **20200498**
 Patient Name: **Testpatient, Donotdelete**
 Date of Birth: **01/18/90** Date of Exam: **06/11/20**

AUTHORIZATION I authorize, **Samantha Mendez RN** (Name of Examiner)

to perform a medical forensic examination, provide treatment, collect evidence, and photograph injuries. I also give permission to release of copies of the complete report to law enforcement for purposes of continuing an investigation.

_____/_____/_____
 Date Signature of Patient, Parent, or Guardian Signature of Witness

If patient is child, who accompanied child for exam? **-/-**
 Name Relationship/Title/Agency

HISTORY AND PHYSICAL EXAMINATION:

Exam beginning time: **1212**

A. Medical History:

Spoken language if other than English: _____ Translators Name: _____
 Past Medical History/Surgeries: **"asthma, UTIs, depression, I don't get my period since the IUD"**
 Current Medications: **"Lexapro, IUD"**
 Medication Allergies: **"Morphine"**
 Last Tetanus: **Up to Date** Hepatitis B Vaccination series? ☒ Yes ☐ No ☐ Unknown
 Date of last menses (mm/dd/yy): **"2017"** ☐ Menstruating at time of exam (Collect tampon or pad as evidence.)
 Does patient use ☐ tampons? ☐ pads? ☒ other? **Does not get menses**

B. Assault History:

As stated by: ☒ Patient ☐ Guardian ☐ Other (Name): _____
 Description Of Assault: _____ Date of Assault: **"Today" - 6/11/2020** Time of Assault: **"Around 2 am"**

"We were drinking at the bar, and I had two drinks. I went to sleep, and when I woke up he was on top of me having sex with me, his penis in my vagina. He kissed me. I tried to push him off but he's stronger than me. This morning I went to the bathroom and it burns to pee. I don't know if he did anything else while I was passed out."

Did the penis penetrate:	<input checked="" type="checkbox"/> Vulva	<input type="checkbox"/> Anus	<input type="checkbox"/> Not Known	<input type="checkbox"/> No
Was there digital penetration?	<input type="checkbox"/> Vulva	<input type="checkbox"/> Anus	<input checked="" type="checkbox"/> Not Known	<input type="checkbox"/> No
Was penetration attempted, but unsuccessful?	<input type="checkbox"/> Vulva	<input type="checkbox"/> Anus	<input checked="" type="checkbox"/> Not Known	<input type="checkbox"/> No
Was there oral – genital/anal contact?	<input type="checkbox"/> Fellatio	<input type="checkbox"/> Cunnilingus	<input type="checkbox"/> Anilingus	<input checked="" type="checkbox"/> Not Known <input type="checkbox"/> No
Was there use of foreign object?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known	<input type="checkbox"/> Yes Describe:		
Did the assailant(s) ejaculate?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known	<input type="checkbox"/> Yes Where:		
Did the assailant(s) wear a condom?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known	<input type="checkbox"/> Yes		
Did the assailant(s) lick/kiss/suck/bite you?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known	<input type="checkbox"/> Yes Where:		
Any form of contraception/lubricant used?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known	<input type="checkbox"/> Yes Describe:		
Identifying features of assailant(s) genitalia? (Marks, sores, tattoos, piercing, size, shaved, circumcised?)	<input type="checkbox"/> No <input checked="" type="checkbox"/> Not Known	<input type="checkbox"/> Yes Describe:		
Was there any use of force?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	Describe: "I was asleep"		
Was there any use of threats?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe:		
Was there any use of intimidation?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe:		
Was a weapon used?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe:		
Number of assailant(s): 1	Sex of assailant(s): M	Ethnicity of assailant(s): "White"		
Does patient know assailant(s)?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	If yes, how? "My friend's friend"		

Examiner's Signature: _____

Title: **BSN, RN, SANE-A**

Patient Name: Testpatient, Donotdelete Date of Examination: 06/11/20	Agency Name: PHOENIX Agency Report #: 123																																																												
Prior to exam/evidence collection has the patient: (If exam is within 120 hours, indicate number of times for each.) <input type="checkbox"/> None Apply																																																													
<table style="width:100%; border: none;"> <tr> <td><input checked="" type="checkbox"/> Urinated "Once"</td> <td><input type="checkbox"/> Showered</td> <td><input checked="" type="checkbox"/> Wiped/washed with urination</td> <td><input type="checkbox"/> Douched</td> <td><input type="checkbox"/> Brushed teeth / used mouthwash / flossed (circle)</td> </tr> <tr> <td><input type="checkbox"/> Defecated</td> <td><input type="checkbox"/> Bathed</td> <td><input type="checkbox"/> Changed clothes</td> <td><input type="checkbox"/> Vomited</td> <td><input type="checkbox"/> Had food / drank / chewed gum (circle)</td> </tr> </table>		<input checked="" type="checkbox"/> Urinated "Once"	<input type="checkbox"/> Showered	<input checked="" type="checkbox"/> Wiped/washed with urination	<input type="checkbox"/> Douched	<input type="checkbox"/> Brushed teeth / used mouthwash / flossed (circle)	<input type="checkbox"/> Defecated	<input type="checkbox"/> Bathed	<input type="checkbox"/> Changed clothes	<input type="checkbox"/> Vomited	<input type="checkbox"/> Had food / drank / chewed gum (circle)																																																		
<input checked="" type="checkbox"/> Urinated "Once"	<input type="checkbox"/> Showered	<input checked="" type="checkbox"/> Wiped/washed with urination	<input type="checkbox"/> Douched	<input type="checkbox"/> Brushed teeth / used mouthwash / flossed (circle)																																																									
<input type="checkbox"/> Defecated	<input type="checkbox"/> Bathed	<input type="checkbox"/> Changed clothes	<input type="checkbox"/> Vomited	<input type="checkbox"/> Had food / drank / chewed gum (circle)																																																									
Condition of patient's clothing: (Describe which article(s) of clothing and location of findings.) <input type="checkbox"/> None Apply <input type="checkbox"/> Wet/damp <input type="checkbox"/> Debris (i.e. grass, leaves, dirt) <input checked="" type="checkbox"/> Missing (explain): "I can't find my underwear" <input type="checkbox"/> Stained/soiled <input type="checkbox"/> Torn <input type="checkbox"/> Other (explain):																																																													
Since the assault does the patient have complaints of: (Describe complaints) <input type="checkbox"/> None Apply <input type="checkbox"/> Muscle pain <input type="checkbox"/> Discharge <input type="checkbox"/> Pelvic pain <input checked="" type="checkbox"/> Painful urination <input type="checkbox"/> Anorectal pain <input checked="" type="checkbox"/> Genital pain "Burning" <input type="checkbox"/> Headache <input type="checkbox"/> Bleeding <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Other (explain): See history																																																													
Other than the assault, has the patient had other sexual contact in the past 120 hours (5 days)? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes If Yes, indicate: Date: Time: Form of contraception used: Describe:																																																													
C. Physical Examination and Evidence Collection: Specimens are collected throughout the exam process.																																																													
BP: 108/70 P: 89 R: 14 T: 98.0 °F Height: 5'4" Weight: 120 <input checked="" type="checkbox"/> lb. <input type="checkbox"/> kg																																																													
Airway: <input checked="" type="checkbox"/> Patent <input type="checkbox"/> Other: Breathing: <input checked="" type="checkbox"/> Regular and Spontaneous Breath Sounds: Clear and equal bilaterally <input type="checkbox"/> Other: Circulation: Mucous Membrane Color: Pink Capillary refill: Less than 2 seconds Skin: <input checked="" type="checkbox"/> Warm <input checked="" type="checkbox"/> Dry <input type="checkbox"/> Cool <input type="checkbox"/> Moist <input type="checkbox"/> Other: Neuro: <input checked="" type="checkbox"/> Alert <input checked="" type="checkbox"/> Oriented <input type="checkbox"/> Other: Pupils: <input checked="" type="checkbox"/> PERL <input type="checkbox"/> Unequal R: mm L: mm																																																													
<table style="width:100%; border: none;"> <tr> <td style="width:20%;">Head/Face/Mouth:</td> <td><input checked="" type="checkbox"/> No Injury Noted</td> <td><input type="checkbox"/> See Injury Log</td> <td><input type="checkbox"/> Comment:</td> </tr> <tr> <td>Neck:</td> <td><input type="checkbox"/> No Injury Noted</td> <td><input checked="" type="checkbox"/> See Injury Log</td> <td><input type="checkbox"/> Comment:</td> </tr> <tr> <td>Chest/Breasts:</td> <td><input checked="" type="checkbox"/> No Injury Noted</td> <td><input type="checkbox"/> See Injury Log</td> <td><input type="checkbox"/> Comment:</td> </tr> <tr> <td>Abdomen:</td> <td><input checked="" type="checkbox"/> No Injury Noted</td> <td><input type="checkbox"/> See Injury Log</td> <td><input checked="" type="checkbox"/> Soft Bowel sounds: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent</td> </tr> <tr> <td>Pelvis:</td> <td><input type="checkbox"/> No Injury Noted</td> <td><input checked="" type="checkbox"/> See Injury Log</td> <td><input checked="" type="checkbox"/> Comment: No injury- RLQ fluoresced</td> </tr> <tr> <td>Upper Extremities:</td> <td><input type="checkbox"/> No Injury Noted</td> <td><input checked="" type="checkbox"/> See Injury Log</td> <td><input type="checkbox"/> Comment:</td> </tr> <tr> <td colspan="4">Fingernails: (Indicate general description, damage, length, edges, polishes, etc.) short, round, smooth edges</td> </tr> <tr> <td>Lower Extremities:</td> <td><input checked="" type="checkbox"/> No Injury Noted</td> <td><input type="checkbox"/> See Injury Log</td> <td><input type="checkbox"/> Comment:</td> </tr> <tr> <td>Back/Buttocks:</td> <td><input checked="" type="checkbox"/> No Injury Noted</td> <td><input type="checkbox"/> See Injury Log</td> <td><input type="checkbox"/> Comment:</td> </tr> </table>		Head/Face/Mouth:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:	Neck:	<input type="checkbox"/> No Injury Noted	<input checked="" type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:	Chest/Breasts:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:	Abdomen:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input checked="" type="checkbox"/> Soft Bowel sounds: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent	Pelvis:	<input type="checkbox"/> No Injury Noted	<input checked="" type="checkbox"/> See Injury Log	<input checked="" type="checkbox"/> Comment: No injury- RLQ fluoresced	Upper Extremities:	<input type="checkbox"/> No Injury Noted	<input checked="" type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:	Fingernails: (Indicate general description, damage, length, edges, polishes, etc.) short, round, smooth edges				Lower Extremities:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:	Back/Buttocks:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:																								
Head/Face/Mouth:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:																																																										
Neck:	<input type="checkbox"/> No Injury Noted	<input checked="" type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:																																																										
Chest/Breasts:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:																																																										
Abdomen:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input checked="" type="checkbox"/> Soft Bowel sounds: <input checked="" type="checkbox"/> Present <input type="checkbox"/> Absent																																																										
Pelvis:	<input type="checkbox"/> No Injury Noted	<input checked="" type="checkbox"/> See Injury Log	<input checked="" type="checkbox"/> Comment: No injury- RLQ fluoresced																																																										
Upper Extremities:	<input type="checkbox"/> No Injury Noted	<input checked="" type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:																																																										
Fingernails: (Indicate general description, damage, length, edges, polishes, etc.) short, round, smooth edges																																																													
Lower Extremities:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:																																																										
Back/Buttocks:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:																																																										
<table style="width:100%; border: none;"> <tr> <td style="width:20%;">Mons Pubis:</td> <td><input checked="" type="checkbox"/> No Injury Noted</td> <td><input type="checkbox"/> See Injury Log</td> <td><input type="checkbox"/> Comment:</td> </tr> <tr> <td>Labia Majora:</td> <td><input checked="" type="checkbox"/> No Injury Noted</td> <td><input type="checkbox"/> See Injury Log</td> <td><input type="checkbox"/> Comment:</td> </tr> <tr> <td>Labia Minora:</td> <td><input checked="" type="checkbox"/> No Injury Noted</td> <td><input type="checkbox"/> See Injury Log</td> <td><input type="checkbox"/> Comment:</td> </tr> <tr> <td>Clitoral Hood:</td> <td><input checked="" type="checkbox"/> No Injury Noted</td> <td><input type="checkbox"/> See Injury Log</td> <td><input type="checkbox"/> Comment:</td> </tr> <tr> <td>Posterior Fourchette:</td> <td><input checked="" type="checkbox"/> No Injury Noted</td> <td><input type="checkbox"/> See Injury Log</td> <td><input type="checkbox"/> Comment:</td> </tr> <tr> <td>Fossa Navicularis:</td> <td><input type="checkbox"/> No Injury Noted</td> <td><input checked="" type="checkbox"/> See Injury Log</td> <td><input type="checkbox"/> Comment:</td> </tr> <tr> <td>Clitoris:</td> <td><input checked="" type="checkbox"/> No Injury Noted</td> <td><input type="checkbox"/> See Injury Log</td> <td><input type="checkbox"/> Comment:</td> </tr> <tr> <td>Urethral meatus:</td> <td><input checked="" type="checkbox"/> No Injury Noted</td> <td><input type="checkbox"/> See Injury Log</td> <td><input type="checkbox"/> Comment:</td> </tr> <tr> <td>Hymen:</td> <td><input type="checkbox"/> No Injury Noted</td> <td><input checked="" type="checkbox"/> See Injury Log</td> <td><input type="checkbox"/> Comment:</td> </tr> <tr> <td>Vagina:</td> <td><input checked="" type="checkbox"/> No Injury Noted</td> <td><input type="checkbox"/> See Injury Log</td> <td><input type="checkbox"/> Comment:</td> </tr> <tr> <td>Cervix:</td> <td><input checked="" type="checkbox"/> No Injury Noted</td> <td><input type="checkbox"/> See Injury Log</td> <td><input type="checkbox"/> Comment:</td> </tr> <tr> <td>Perineal body:</td> <td><input checked="" type="checkbox"/> No Injury Noted</td> <td><input type="checkbox"/> See Injury Log</td> <td><input type="checkbox"/> Comment:</td> </tr> <tr> <td>Anus:</td> <td><input checked="" type="checkbox"/> No Injury Noted</td> <td><input type="checkbox"/> See Injury Log</td> <td><input type="checkbox"/> Comment:</td> </tr> <tr> <td>Penis:</td> <td><input type="checkbox"/> No Injury Noted</td> <td><input type="checkbox"/> See Injury Log</td> <td><input checked="" type="checkbox"/> Comment: Not applicable</td> </tr> <tr> <td>Scrotum:</td> <td><input type="checkbox"/> No Injury Noted</td> <td><input type="checkbox"/> See Injury Log</td> <td><input checked="" type="checkbox"/> Comment: Not applicable</td> </tr> </table>		Mons Pubis:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:	Labia Majora:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:	Labia Minora:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:	Clitoral Hood:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:	Posterior Fourchette:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:	Fossa Navicularis:	<input type="checkbox"/> No Injury Noted	<input checked="" type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:	Clitoris:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:	Urethral meatus:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:	Hymen:	<input type="checkbox"/> No Injury Noted	<input checked="" type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:	Vagina:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:	Cervix:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:	Perineal body:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:	Anus:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:	Penis:	<input type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input checked="" type="checkbox"/> Comment: Not applicable	Scrotum:	<input type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input checked="" type="checkbox"/> Comment: Not applicable
Mons Pubis:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:																																																										
Labia Majora:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:																																																										
Labia Minora:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:																																																										
Clitoral Hood:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:																																																										
Posterior Fourchette:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:																																																										
Fossa Navicularis:	<input type="checkbox"/> No Injury Noted	<input checked="" type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:																																																										
Clitoris:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:																																																										
Urethral meatus:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:																																																										
Hymen:	<input type="checkbox"/> No Injury Noted	<input checked="" type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:																																																										
Vagina:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:																																																										
Cervix:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:																																																										
Perineal body:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:																																																										
Anus:	<input checked="" type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input type="checkbox"/> Comment:																																																										
Penis:	<input type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input checked="" type="checkbox"/> Comment: Not applicable																																																										
Scrotum:	<input type="checkbox"/> No Injury Noted	<input type="checkbox"/> See Injury Log	<input checked="" type="checkbox"/> Comment: Not applicable																																																										
Examiner's Signature: _____ Title: BSN, RN, SANE-A																																																													

Patient Name: Testpatient, Donotdelete		Agency Name: PHOENIX	
Date of Examination: 06/11/20		Agency Report #: 123	

Vaginal wet mount for sperm performed?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Present?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Motile?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
--	------------------------------	--	----------	------------------------------	-----------------------------	---------	------------------------------	-----------------------------

Stage of Sexual Maturity (genital development):	<input type="checkbox"/> I	<input type="checkbox"/> II	<input type="checkbox"/> III	<input type="checkbox"/> IV	<input checked="" type="checkbox"/> V			
---	----------------------------	-----------------------------	------------------------------	-----------------------------	---------------------------------------	--	--	--

If indicated:	No	Yes	Type/Results/Comments, if indicated
Alternate Light Source used?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Record fluorescent area(s) on <i>Findings/Injury Log and Body Map(s)</i>
<input checked="" type="checkbox"/> Pregnancy test	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Serum <input checked="" type="checkbox"/> Urine <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Positive
STI Cultures/Tests	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Blood <input type="checkbox"/> Cultures <input type="checkbox"/> LCR <input type="checkbox"/>
<input type="checkbox"/> Drug Screen sample(s) collected	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Blood <input type="checkbox"/> Urine
Colposcope images taken:	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Photographs taken:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	By: S. Mendez
Treatment Given:	No	Yes	Explain
STI Prophylaxis:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Zithromax 1 Gm Oral
			Ceftriaxone 250 mg IM
			Prescription given - see Standing Orders
Pregnancy Prophylaxis:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Plan B 1.5mg PO
Other Medications:	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

Discharge Instructions/Follow-up:

☐ Referral to other Facility/Physician:

☒ Appointment in 2-4 weeks for recheck: ☒ Pregnancy ☒ STI Tests

☐ Other:

General appearance and behavior during exam : crying, flat affect, shaking during history of assault

Additional Notes: 1321 Medical forensic exam completed. Medication teaching done. Discussed patient's option for medication. 1330 Ceftriaxone, azithromycin, and Plan B administered for STI and pregnancy prophylaxis per standing orders. Prescription given for Metronidazole due to history of recent alcohol consumption. 1335 Aftercare instructions reviewed verbally and in writing. Copy given. 1345 Patient discharged to care of victim's advocate.

Exam Ending Time (Discharge): 1345

Examiner's diagnosis:

Sexual assault by history

Minor physical injury by exam

Minor genital injury by exam

Evidence of penetration of vulva by exam

Crime Lab Results Pending

Examiner's Signature:	Title: BSN, RN, SANE-A
------------------------------	--------------------------------------

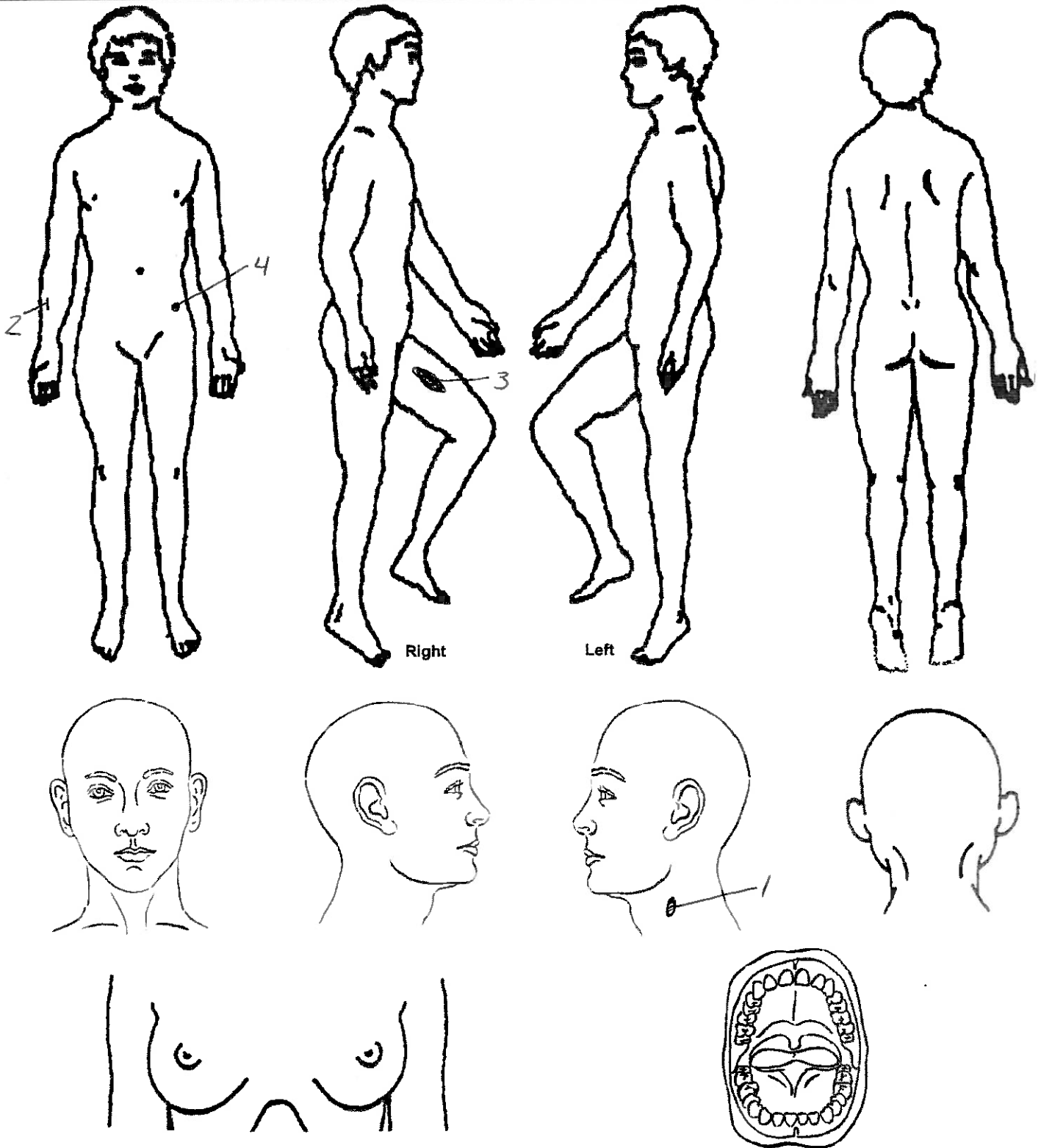
Patient Name: *Testpatient, Donotdelete*

Agency Name: **PHOENIX**

Date of Examination: *06/11/20*

Agency Report #: **123**

Body Map #1 Shade area of injury and assign number to each injury. Describe each injury on Findings/Injury Log.
If additional space is needed to document injury, copy this sheet prior to use.



Examiner's Signature: _____

Title: **BSN, RN, SANE-A**

Patient Name: *Testpatient, Donotdelete*

Agency Name: *PHOENIX*

Date of Examination: *06/11/20*

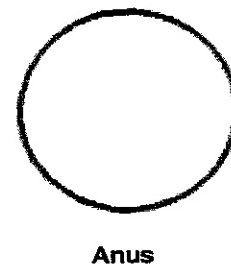
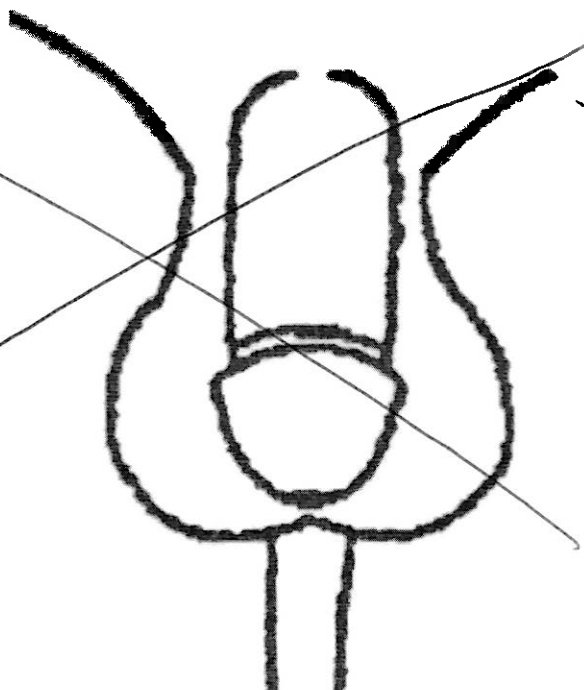
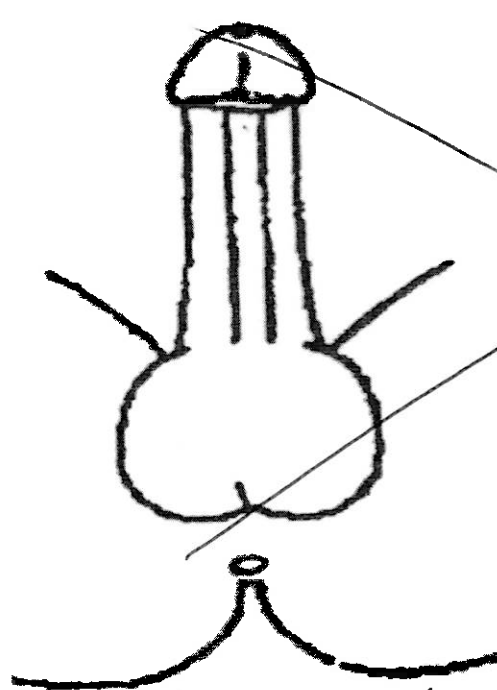
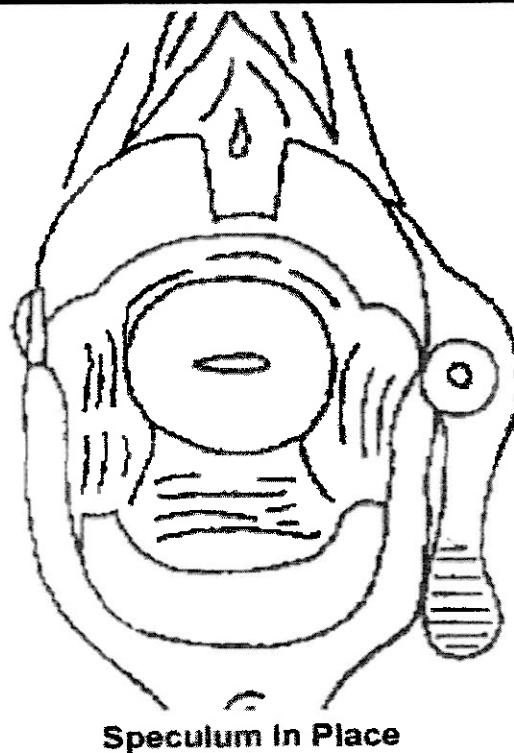
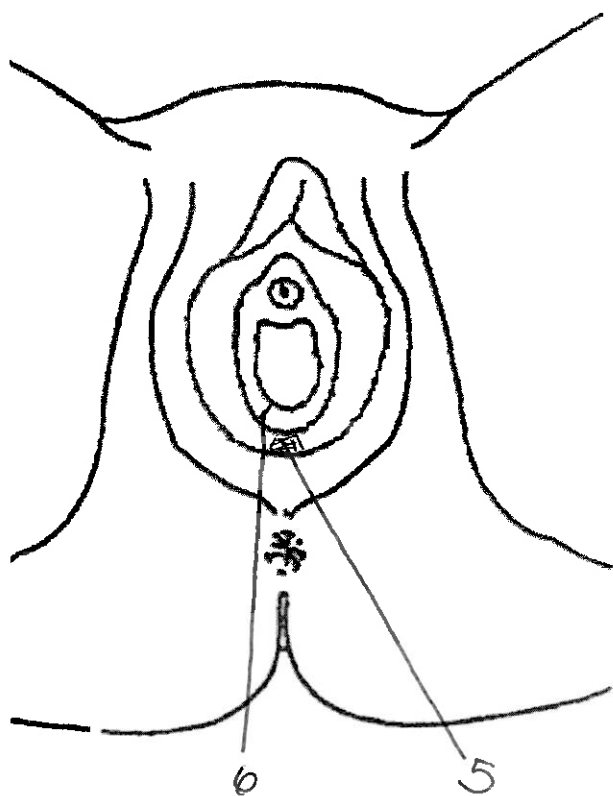
Agency Report #: *123*

Body Map #2

Shade area of injury and assign number to each injury.

Describe each injury on Findings/Injury Log.

If additional space is needed to document injury, copy this sheet prior to use.



Examiner's Signature: _____

Title: *BSN, RN, SANE-A*

Agency Name: **PHOENIX**

Agency Report #: 123

If additional space is needed to document injury, copy this sheet prior to use. All measurements should be in centimeters.

[illegible]

A = Abrasion	E = Erythema	L = Laceration (tear)	S = Surface (body) swab
B = Burn	EC = Ecchymosis	O = Other	T = Tenderness
C = Cut (Incision)	ED = Edema	P = Petechiae/Purpura	
CN = Contusion	F = Fluorescent area	PW = Puncture wound	

Copy hospital records documenting care received related to this event. These records are to accompany this report. Include nurses' notes and pre-hospital reports: ☒ Not applicable ☐ Done ☐ Not obtained

Examiner's Name printed: *Samantha Mendez* **Title:** *BSN, RN, SANE-A*

Examiner's Signature: _____ **Title:** *BSN, RN, SANE-A*

Sexual Assault Aftercare Instructions

Name: **Testpatient, Donotdelete**Date: **06/11/20**MR#: **20200498**DR#: **123**Forensic Nurse Examiner: **Samantha**Diagnosis: ☒ **Sexual assault by history** ☐ **Physical Assault** ☐ **Intimate Partner Violence**☐ **Other:**

Today's Examination:

Examination: A Medical-Forensic Examination was completed to identify and document areas of possible injury, provide care, and collect samples and clothing that may be examined as part of the investigation of your assault. Some of the care provided may include prevention for sexually transmitted diseases and pregnancy as well as recommendation for follow-up care as outlined below.

Evidence Collection: Samples and clothing **may** be examined for evidence. The detective assigned to your case will determine what testing may be required by the crime laboratory on the samples and clothing collected today. Any results of this testing will go directly to the detective assigned to your case and will become part of the legal record of this assault. Please contact the detective with any questions regarding this part of the process.

Photographs: Photographs may have been taken that show the visible injuries to your body. If injuries become more visible in the next few days, notify the police department or your Case Detective to see if additional photographs taken are needed.

Sexually Transmitted Infections (STIs): You are at risk of getting **any** infections that are transferred through bodily secretions. Today's examination cannot tell if you had a sexually transmitted infection prior to the assault or as a result of the assault. Not all sexually transmitted infections can be prevented. **Additional information is available for you to read in your packet.** It is recommended that you abstain from sexual intercourse or use a condom until your follow-up exam.

You **Did not** have testing today for sexually transmitted diseases. If testing **was** done, call our office at 480-312-6340 after for the results.

You may have received antibiotic medications to attempt to prevent some sexually transmitted infections such as Gonorrhea, Chlamydia, and Trichomonas. Alcohol can cause severe reactions with some antibiotics and can make you very sick. Avoid drinking alcohol or using products that contain alcohol (mouthwash, perfume, liquid medicines) for the next 2-3 days. **You received a prescription for antibiotics today. Get the prescription filled as soon as possible. Take as directed**

Pregnancy Testing: Preventing pregnancy is often a major concern. The chance of getting pregnant from a single, unprotected intercourse varies. A pregnancy test **Was** done today. **The results were Negative**

Emergency Contraception Pills (ECPs): Emergency Contraception Pills (ECPs), also known as "morning after pills", are effective contraceptives that can be taken within 72-120 hours after unprotected sex. They are birth control pills that are used in a different way. Though not recommended as a regular contraception method, ECPs can reduce the risk of pregnancy by about 75% during the most fertile days of your cycle. ECPs do not interrupt an already established pregnancy. When using ECPs, the medication is taken as soon as possible after unprotected sex (within 3-5 days), and depending on the medication, a second dose is taken 12 hours later. Studies show there are no lasting side effects from ECPs.

You **did receive** a hormone medication to help prevent the possibility of pregnancy.

After taking this medication you may experience:

- o upset stomach (nausea)
- o headache
- o bloated feeling
- o vomiting
- o dizziness
- o disrupted menstrual cycle (your period may come sooner or later than expected)
- o breast tenderness
- o fatigue or tired

Tetanus Vaccine: You **Did not** receive a tetanus vaccine.

Your examination and treatment today was provided on an emergency basis only. This is not a substitute for, or an effort to provide complete medical care. You must let your health care provider check you again. Tell your health care provider about any new or lasting problems. It is impossible to recognize all injuries or illnesses that may result from a sexual and/or physical assault in a single examination. It is possible that no injuries are found.

Medical Direction: **Dr. Charles Finch, D.O.**

If you have questions regarding your examination, please call 480-312-6340.

Follow-up Care Recommendations:

Counseling: Early counseling is recommended to help prevent lasting complications associated with this type of assault. Your discharge packet contains a list of counseling options for your consideration.

Medical Follow-up: Follow-up examination is recommended *in the next 14-21 Days, sooner if problems develop*
You should be re-evaluated for: *Sexually Transmitted Infections. Pregnancy.*

Call as soon as possible to schedule an appointment with your doctor or at clinic for testing.

HIV Testing and Prevention Treatment: The risk for transmission of HIV is extremely low. Medications for exposure to HIV must be started within 72 hours. Follow up testing for HIV is recommended for a period of 6 months. You should be tested for HIV now, in 6 weeks, at 3 months and at 6 months for accurate results. You may see your own physician, contact the Maricopa County Public Health STD/HIV Services

602-506-6900, or at NOAH **480-882-4545**, or NOAHHELPS.org for an up to date list of Valley-wide locations.

Services available at the Maricopa County Public Health STD/HIV Center include:

- Complete STD testing and treatment
- HIV testing and counseling
- Pregnancy testing

Services available at the NOAH Neighborhood Outreach Access to Health include:

- Complete STD testing and treatment
- HIV testing, prophylaxis and prevention
- Pregnancy testing
- Family Medicine
- Pediatric Services
- Prenatal Services
- Behavioral Health
- Psychiatric Services
- Dental Services
- Nutrition Services
- Community Resources

Additional Instructions:

Lacerations, Cuts, Abrasions:

- ☐ A **laceration** is an open skin wound that results from overstretching the skin or blunt force trauma (injury). There is no skin missing but it is separated and may be jagged or irregular. It will usually bleed.
- ☐ A **cut** is also a separation in the skin or tissue caused by a sharp object, such as a knife, piece of glass or razor blade. This type of injury will also bleed.
- ☒ An **abrasion**, or scrape, occurs when the top few layers of skin are scraped off.

Care of lacerations, cuts, and abrasions:

- Wash hands before and after touching the area.
- Keep the wound clean by gently washing with mild soap and water 2 to 3 times each day to decrease chances of infection.
- If the area has a dressing or band-aid on it, keep it dressed or covered with a band-aid for at least the first two days. Change the dressing if it becomes wet or soiled
- Elevate the affected area if possible to increase healing.
- If bleeding starts again, apply pressure directly over the wound with a clean cloth or gauze.
- You may also use a thin layer of antibiotic ointment, such as Bacitracin ointment, on the wound.
- If your wound was closed using steri-strips, leave these in place for at least 5 to 7 days.

Call your doctor if you have: increased redness or swelling, red streaks coming from the wound, drainage that is not clear coming from the wound (yellow, white, or green), developed a fever or any new or severe symptoms.

Contusions (Bruises): An injury caused by a blunt object or force. The force of the injury causes blood vessels under the skin to break, which may result in swelling or discoloration of the skin and pain. As it heals, the swelling will decrease and the color may change. Discoloration may not appear until a few days after the injury occurred.

Care of contusions:

- Apply ice packs for twenty minutes, four times per day for the first two-three days after the injury occurred. Cover the ice pack with a thin cloth to protect skin from cold and further injury.
- If possible, elevate the area where the contusion is above heart level to decrease swelling.

Call your doctor if you have: severe pain, excessive swelling, numbness or tingling below the injury, inability to move the injured part or new symptoms.

Strangulation: Is the disruption of a person's normal air and blood passage in the neck by hands or an object, such as a rope. Although there may be no visible signs of strangulation, there may be numerous effects from it. Strangulation may cause a sore throat, difficulty swallowing or breathing, ringing of the ears, a raspy or hoarse voice, small broken blood vessels on the neck, face and scalp, reddened eyes, heartburn and feelings of "head rush". If pregnant, a miscarriage may occur. Memory problems, anxiety, insomnia, nightmares, and depression may also occur.

Care following strangulation:

- o For comfort, drink extra water for hydration. Cool liquids may also help a sore throat.
- o You may have small broken blood vessels on your neck or anywhere on your head. These should heal within a few days.
- o If you are having anxiety, feeling depressed, having nightmares or insomnia as a result, please consider counseling to assist you with these feelings and to help prevent or decrease the chances of developing post-traumatic stress problems.

Call your doctor if you have: loss of consciousness, lightheadedness, shortness of breath, loss of bodily functions or difficulty swallowing.

Genital / Anal Injuries: May be very painful and may bleed for a day or two. The area heals quickly, usually in 2 or 3 days.

Care of genital and anal injuries:

- o Keep the area clean and dry.
- o Pat the area dry after urinating.
- o Apply ice packs for twenty minutes, four times per day for the first 2 to 3 days after the injury occurred to decrease swelling. Cover the ice pack with a thin cloth to protect skin from cold and further injury.
- o Take a sitz bath several times a day. Sit in a small amount of warm water for about 5 minutes and pat the area dry after the bath.
- o Use acetaminophen (i.e. Tylenol) or ibuprofen as recommended for pain relief.

Call your doctor if you have: uncontrolled bleeding that is not your period, have pain or difficulty urinating, develop pain that becomes severe, or you develop a fever.

Head Injury (Concussion): An injury to the brain from a blow to the head or by a fall. It may result in headaches, dizziness, ringing in the ears, double vision, memory changes, personality changes, difficulty concentrating or fatigue. Symptoms may last from days to years.


Care following a head injury:

- o A friend or family member should wake you up every two hours during the first night after the head injury occurred. If they cannot awaken you, they should call your doctor.
- o Rest for the first few days after the injury. Resume regular activities when you feel able.
- o Apply ice packs to the sores area for twenty minutes, four times per day for the first 2 days for comfort. Cover the ice pack with a thin cloth to protect skin from cold and further injury.
- o Eat foods such as toast, rice, yogurt and tea if you have an upset stomach.
- o Use Tylenol for headache (NOT aspirin)


Call your doctor if you have: difficulty hearing, changes in your vision, a severe headache unrelieved by pain relievers, extreme drowsiness, lose memory of the event (amnesia), vomiting, confusion, trouble with your balance, or problems talking.

I understand the instructions written above and discussed by the Sexual Assault Nurse Examiner.

I have received all of my personal belongings, except those taken as evidence.



Patient or Authorized Representative Signature

Samantha BSN, RN, SANE-A 

Forensic Nurse Examiner

Sexual Assault Physician's Standing Orders

Patient Name: Testpatient, Donotdelete

Date: 06/11/20 DOB: 01/18/90

MR#: 20200498

TIME DONE/INITIALS

1212/SM☒ **Initiate Sexual Assault Care Protocol****1. Pregnancy Test**
☒ Urine ☐ Serum
 Results: ☐ Positive ☒ Negative
1326/SM**2. STI Testing**
☐ Urogenital Culture site(s):
☐ GC Culture site(s):
☐ RPR ☐ Herpes ☐ HIV
☐ Chlamydia Culture site(s)
 / **3. Pregnancy Prophylaxis**
☒ Plan B® 1.5mg PO now
Presumptive prophylaxis is administered to post-pubescent patients only
1330/SM**4. STI Prophylaxis**
☒ Ceftriaxone (Rocephin®) 250mg IM now
 (If no allergies to cephalosporins or PCN)
☒ Azithromycin (Zithromax®) 1GM PO now
 (If no allergies to erythromycin or macrolides)
☐ Metronidazole (Flagyl®) 2GM PO now
 (If no allergies to metronidazole, no alcohol use
 within 24 hours and not in the first trimester of
 of pregnancy)
1330/SM1330/SM / **5. Prescription**

Fill prescription and take medication as directed for:

☐ Zithromax® 250mg tablets.
 Take four (4) tablets at one time
☐ Cefixime® one (1) 400mg tablet
☒ Flagyl® 500mg tablets
 Take four (4) tablets at one time
 / / 1330/SM
☐ Plan B® 1.5mg
 Take as soon as possible
 / **6. Antiemetic**☐ Phenergan® 25mg PO now / **7. Pain/Discomfort**
☐ Tylenol® 325mg
 Two (2) tablets now for pain/discomfort
 / **8. Tetanus**☐ Tdap 0.5cc IM / **9. Other** / **Traumatic Brain Injury Screening** / **Behavioral Health Crisis Screening**

Yes

1240/SM**Sexual Exploitation Screening**

Yes

1240/SM

Discharge Plan

Stable for discharge with aftercare instructions

1345/SM

Diagnosis

Sexual assault by history

1321/SM

____/____

____/____

Dr. Charles Finch, D.O.

RN